Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health dba Injury1 of Dallas

Respondent Name
Cherokee Insurance Co

MFDR Tracking Number
M4-14-0231-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
September 23, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services were provided and the claims were returned back with letter from adjuster. The treatment that was provided is part of his compensable injury to his should that he sustained… Also, treatment was preauthorized."

Amount in Dispute: $9,323.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As this treatment was not administered for the compensable injuries, and because the Carrier is obligated to pay (or not pay) benefits in accordance with the Designated Doctor's opinion, pursuant to Tex. Lab. Code §408.0041(f), no reimbursement for these services is owed."

Response Submitted by: Adami, Shuffield, Scheihing, & Burns

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2012	90882		
November 26, 2012	90806		
December 3, 2012	80806		
December 10, 2012	90806		
December 19, 2012	90806		
December 26, 2012	90806	$9,323.54	$4,541.06
January 2, 2013	90806		
January 11, 2013	96118		
January 11, 2013	96116		
March 6, 2013	96151		
April 26, 2013	90882		

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 sets out definition of terms adopted by the Division related to medical

billing and processing for health care services.

3. 28 Texas Administrative Code §133.200 sets out guidelines for insurance carriers receipt of medical bills.
4. 28 Texas Administrative Code §133.204 sets out guidelines related to paper explanation of benefits.
5. The services in dispute were **returned** as unprocessable by the respondent with the following reason codes:
   - Other: Psych treatment disputed on 11/2/12 & 11/16/12 via PLN
   - Other: Treatment is related to disputed conditions.
   - Other: Treatment is for disputed conditions

Issues

1. Did the respondent appropriately reject the medical bill in dispute?
2. Did the respondent appropriately raise issues of compensability or extent?
3. Is the additional reimbursement due to the requestor?

Findings

1. 28 Texas Labor Code 133.200(a) states in pertinent part, "Upon receipt of medical bills…, an insurance carrier shall evaluate each medical bill for completeness as defined in §133.2 …" (1) Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill. (b) An insurance carrier shall not return a medical bill except as provided in subsection (a) of this section. Review of the submitted documentation finds that the requestor submitted a complete medical bill in accordance with 28 Texas Labor Code 133.200(a) and corresponding 28 Texas Labor Code §133.2. The carrier's reason for rejection is not supported because it is not part of the definition of a complete medical bill. The Division finds the carrier improperly rejected the medical bill. The Division further concludes that the carrier did not meet the requirements of 28 Texas Labor Code §133.200.

2. In its response to medical fee dispute resolution, the carrier states, in pertinent part, that "this treatment was not administered for the compensable injuries." According to 28 Texas Administrative Code §133.240(e), (e)(2)(C), the carrier is required to issue an explanation of benefits in the form and manner prescribed by the Division to the health care provider and the injured employee when denying payment due to "(C)unrelated to the compensable injury, in accordance with §124.2 and 124.3 of this title." Although the carrier mentions compensability and extent in its improper rejection of the medical bill as discussed in paragraph one, no documentation was found to support that the carrier issued the electronic or paper explanation of benefits that contained all the elements required by §133.240(e). The Division concludes that the carrier did not meet the requirements of 28 Texas Administrative Code §133.240

3. For the reasons state above, the services in dispute are eligible for payment pursuant to 28 Texas Administrative Code 134.203(c)1. For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service conversion factor). The Maximum Allowable Reimbursement is therefore calculated as follows:

Date of Service	Submitted Code	Units	Amount Billed	MAR	Amount Due
November 15, 2012	90882	1	$150.00	Non-covered service	$0.00
November 26, 2012	90806	1	$145.00	(54.86 / 34.0376) x 82.48 = $132.94	$132.94
December 3, 2012	80806	1	$145.00	(54.86 / 34.0376) x 82.48 = $132.94	$132.94
December 10, 2012	90806	1	$145.00	(54.86 / 34.0376) x 82.48 = $132.94	$132.94
December 19, 2012	90806	1	$145.00	(54.86 / 34.0376) x 82.48 = $132.94	$132.94
December 26, 2012	90806	1	$145.00	(54.86 / 34.0376) x 82.48 = $132.94	$132.94
January 2, 2013	90806 new code 90834	1	$145.00	(55.3 / 34.023) x 81.06 = $132.94	$131.75
January 11, 2013	96118	20	$7,000.00	(55.3 / 34.023) x 94.28 = $3,006.29	$3,006.29
January 11, 2013	96116	4	$900.00	(55.3 / 34.023) x 89.53 = $145.52 x 4 units = $582.08	$582.08
March 6, 2013	96151	8	280.00	(55.3 / 34.023) x 19.53 = $31.74 x 8 units = $156.24	$156.24
April 26, 2013	90882	1	$150.00	Non-covered service	$0.00
		TOTAL	$9,200.00		$4,541.06

The total MAR for the services in dispute is $4,541.06. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,541.06.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $4,541.06 reimbursement for the disputed services.

Authorized Signature

		June 30, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.